AHCCCS MEDICARE RESEARCH REQUEST FORM

Instructions

Mail form to:

AHCCCS ADMINISTRATION
MFIS, Mail Drop 3600
801 E. Jefferson
Phoenix, AZ. 85034

Form(s) can be Faxed to **AHCCCS/MFIS at (602) 253-4807**
or Providers can direct questions to **Cecilia Ruiz in DMS at (602) 417-4599**.

To assist our customers in maintaining the integrity of the client's information and to comply with requests to research the client's Medicare information, please fill out the attached form. Please print or type.

Date the form.

1. Enter the Client's AHCCCS ID number.
2. *Enter the Client's name.
3. *Enter the Client's date of birth.
4. *Enter the Client's Social Security number.
5. *Enter the Client's Medicare Claim number (if known). Some client's will have a Medicare Claim number that indicates that they are receiving benefits under a spouse/parent. This claim number will be different from the client's Social Security number.
6. Enter the Client's Part A begin date and/or end date (if known).
7. Enter the Client's Part B begin date and/or end date (if known).

On the bottom section of the form please Enter:

- the name of the health plan/program contractor and/or the provider;
- the telephone number of the person requesting that Medicare be researched;
- and the signature of the person requesting the research.

AHCCCS MEDICARE RESEARCH REQUEST FORM

To help us research member Medicare data, please complete this form(s), sign, date and return it to:
AHCCCS ADMINISTRATION
MFIS, Mail Drop 3600
801 E. Jefferson
Phoenix, AZ. 85034 or Fax completed form(s) to **AHCCCS/MFIS at (602) 253-4807.**
Please print or type. Fill as much information as possible in the spaces below, fields with asterisk are **required.**

RECIPIENT MEDICARE INFORMATION

Date:_____

1. AHCCCS ID #: _____
2. *Name: _____
3. *Date of Birth: _____
4. *Social Security Number: _____
5. *Medicare Claim Number: _____
   (Various beneficiaries will have a Medicare Claim Number different from their Social Security Number.)

   (Please indicate the begin and end dates, for Part A and Part B, if known).
6. Part A Begin Date: _____ / Part A End Date:_____
7. Part B Begin Date: _____ / Part B End Date:_____

Health Plan/Program Contractor/Provider Information

Name of Health Plan/Program Contractor/Provider**:**

_____

Telephone Number: _____

Signature of Person Completing Form: _____

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